UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

Doris R. King
1395 Commonwealth Ave.
Apt. 32
Allston, Ma. 02134

Civil Action # 03-12591-RGS

West Roxbury VAMC & Mary Hanlon
U.S. Department of Veterans Affairs
Office of Regional Counsel
VAMC
200 Spring Road, Building 61
Bedford, Ma. 01730

COMPLAINT

PARTIES

1. The Plaintiff is a resident of Allston, Ma, in Sufford County and a U. S. citizen.

2. The Defendant is_____

JURISDICTION

3. The jurisdiction is Federal Court because it has limited/specific jurisdiction. My case is against a Federal agency.

4. On June 9, 2001, at the W. Roxbury VAMC, an employee, Mary Hanlon gave me the wrong medication. The medicine was intended for another patient in my room, Helen Jones, a cancer patient. Nurse Hanlon had explained to me that this was a special medication ordered by my doctor. When it came for the pharmacy, she had to add the magnesium to it. She hung the IV bag and the medicine began to flow into my veins. I told Nurse Hanlon that the medicine was burning me. She replied by saying 'you people from JP are a pain in the ass' and walked out of the room.

5. I rang the nurses' button to complain about the burning. About 20 minutes later, Nurse Hanlon came running into the room. She looked at the IV bag and said "Oh shit I gave you the wrong medicine, this medicine was intended for Mrs. Jones'. She took the IV bag down and threw it into the trashcan. However, she didn't remover the IV tubing or the needle from my arm and the medicine was still continued flowing into my veins and still burning. I removed the needle myself.

6. I told Nurse Hanlon that I was feeling sick and had pressure on my chest. I told her that she had given me the wrong medicine and it was making me sick. Nurse

Hanlon's reply was 'yes I did it so what'. Nurse Hanlon left the room and the hospital without reporting the incident. I continued to get sicker and sicker; stomach pains, vomiting, pressure on my chest, chills and a shortage of breath.

7. I reported the incident to her Supervisor, John, who reported it to his supervisor.

8. I was subjected to racial slurs and connotations by Nurse Hanlon such as 'you people from J. P. VA are pains in the ass' and 'you people are nothing but trouble' and 'that's why we didn't want you people over here' and references to me as 'one of those people'. This was a violation of my civil rights.

9. The nursing staff on ward AG neglected me and I lay helpless in blood and feces for over 6 hours. I had told Nurse Hanlon that I was going to call my family about the way that I was being treated, she said that she didn't care who I called. My mother has been a nurse for over 50 years. When my mother came to see me, Nurse Anita blocked the doorway saying that 'you can't go in there, she has not been cleaned up yet'. As an inpatient I have the right to communicate freely and privately with my visitors. Nurse Anita tried to prohibit my mother from entering my room, but my mother said that no one was going to keep her from seeing her child. My mother was shock at the level of neglect that I was being exposed to and she began to wipe me down and clean me up. Other family members arrived and there was over 100 years of medical experience in my room. My family was discussed and appalled at the way I was being treated and the filthy condition of my room. My sister put the overflowing trash can outside my room. I told them that I had rung my nurses' button several times but no one came to help me. Because I had to lay in blood and feces, the VA nursing staff failed in its commitment to provide the highest quality of health care.

10. I was in terrible pain, crying and I had asked several times for some pain medicine. I waited over six hours for the medicine. It wasn't until after my family had arrived and the Supervisor of nurses was notified that I received pain medicine. The VA employees failed in their promise that I would be treated with dignity, compassion and respect. They also failed to support my rights as a human being.

11. Nurse Hanlon was very rude to my family and after they saw the filthy conditions of my room, they wanted to take me to another hospital. They spoke to the chief of medicine and he advised and explained to my family that it would not be in my best interest to be transferred to another hospital at this time. He suggested that I be transferred off AG to another floor. Dr. Oates also explained to me that I had been worked up for an upper GI, colonoscopy and several other exams. He felt that a transfer to another hospital would set my treatment back several days. I also spoke to my Primary Care Physician, Dr Susan Frayne, at JP. She also encouraged me to stay in the hospital. I would be transferred to another floor and a morphine PCA would be used for better pain control.

12. I was transferred to 2 South and I felt that I had just left the twilight zone. 2 South was like being in heaven. The room was immaculately clean and the nurses were

very cheerful and they gave me excellent health care. However, a family member stayed with me. They wanted me out this VA facility as soon as possible. My brother and sister both told me that they were afraid that something would happen to me because I told on Nurse Hanlon. They feared retaliation.

13. Helen Jones, who was my roommate and the person that was suposed to get the medicine that I received. She got very upset about the way that I was being treated. She was to have a surgerical procedure done on Monday 6/11. Mrs. Jones was so afraid and scared that she checked herself out of the hospital. Mrs. Jones felt that if they could make such a mistake with me when I was awake, many things could happen to her on Monday when she would be unconscious. On Monday 6/11, she reported the incident to Kathleen Stevens in Medical Administration, VAMC at JP. She also gave a statement to Marie Pizzi-Perri, the Nursing Coordinator at WR. Other people that knew about the incident were Mary Baxter, Patient Rep. at JP and Patricia Robinson, Women Vet Coordinator at JP.

14. Marie Pizzi-Perri, the Nursing Coordinate at WR, came to my room to take a statement from me about the incident. Mrs. Pizzi-Perri stated that Mrs. Jones' recall of the event was the same as mine so it must be true. She also said that 'we knew things were bad on AG, they just didn't know how bad they were'. She also said that this wasn't Nurse Hanlon's first complaint, there were several incidents in her personal file. She stated that Nurse Hanlon was going to be suspended for this incident. However, I found out later that Nurse Hanlon was only transferred to another floor and that she received no disciplinary action. The VA knew about the distruction that was happening on AG, yet they allowed it to continue putting patient after patient at risk.

15. I requested copies of the statements taken about the incident. I was told that they would be in my medical records, however they were not there. I wasn't allowed access to have any information about the investigation. Some of my medical records are missing. I was not given the chance to have my question answered during or about the investigation process.

16. Upon discharge I went to see my PCP Dr. Susan Frayne at JP, she was very distrubed about my treatment at WR. She suggested that I needed some therapy to overcome the trauma that I had experienced. I took her suggestion.

17. WRVA knew that there problem on ward as AG, especially the nursing problems. They knew that Nurse Hanlon's and others behaviors made the environment there unsafe for patients. They also failed in their goal to provide the right cares at the right time and at the right level to compassionately meet my needs. I am still in therapy to help me cope with this trauma. I have even had to take depression medicines to help me. I have nightmares about what happened to me. I get sick thinking about getting sick. I am afraid to get sick and afraid to go to the hospital. When I in the hospital I'm so nervous and afraid that this may happen to me again. This makes the healing process much longer. The physical, emotion and psychological effects of the trauma have been and still are very overwhelming. I'm

scarred and permanently damaged because of this trauma. I have many medical problems and I am often hospitalized. I have that right to treatment with dignity, compassion and respect. When I need inpatient care and I seek it at other medical facilities and now I have huge medical bills that I can not pay.

I recently received a letter from Edward J Lukey from the office of Regional Counsel. His letter states the 'our investigation found no evidence of a negligent or wrongful act or omission by a Department of Veterans Affairs employee acting within the scope of his or her employment causing claimant's alleged injury'. With the missing of some of my medical records and this letter I feel that this matter is being covered up. If a proper investigation had been conducted there is no way that they could have come to this conclusion and made this decision. Indeed the VA has failed in its efforts again to do the right thing and in its effort to conduct a fair investigation. Wherefore the Plaintiff demands judgement against the defendants for damages in the amount of $1,000,000.

The Plaintiff requests a trial by jury.

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12/20/03